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BEFORE THE
PHYSICAL THERAPY BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:

JANE E. SAVAHELI
P O Box 491103
Los Angeles, CA 90049

Physical Therapist No. PT 9186

Respondent.

Case No. 1D-2000-62592

FIRST AMENDED
A C C U S A T I O N

Complainant alleges:

PARTIES

1. Steven K. Hartzell (Complainant) brings this First Amended Accusation solely in his official capacity as the Executive Officer of the Physical Therapy Board of California, Department of Consumer Affairs.

2. On or about June 22, 1979, the Physical Therapy Board of California issued Physical Therapist Number PT 9186 to Jane E. Savaheli (Respondent). The Physical Therapist License was in full force and effect at all times relevant to the charges brought herein and will expire on July 31, 2003, unless renewed.

JURISDICTION

3. This First Amended Accusation is brought before the Physical Therapy

Board of California (Board), under the authority of the following sections of the Business and Professions Code (Code).

4. Section 2609 of the Code states:

The board shall issue, suspend, and revoke licenses and approvals to practice physical therapy as provided in this chapter.

5. Section 2660 of the Code states:

The board may, after the conduct of appropriate proceedings under the Administrative Procedure Act, suspend for not more than 12 months, or revoke, or impose probationary conditions upon, or issue subject to terms and conditions any license, certificate, or approval issued under this chapter for any of the following causes:

(a) Advertising in violation of Section 17500.

(b) Fraud in the procurement of any license under this chapter.

(c) Procuring or aiding or offering to procure or aid in criminal abortion.

(d) Conviction of a crime which substantially relates to the qualifications, functions, or duties of a physical therapist. The record of conviction or a certified copy thereof shall be conclusive evidence of that conviction.

(e) Impersonating or acting as a proxy for an applicant in any examination given under this chapter.

(f) Habitual intemperance.

(g) Addiction to the excessive use of any habit-forming drug.

(h) Gross negligence in his or her practice as a physical therapist.

(i) Conviction of a violation of any of the provisions of this chapter or of the State Medical Practice Act, or violating, or attempting to violate, directly or indirectly, or assisting in or abetting the violating of, or conspiring to violate any provision or term of this chapter or of the State Medical Practice Act.

(j) The aiding or abetting of any person to violate this chapter or any

regulations duly adopted under this chapter.

(k) The aiding or abetting of any person to engage in the unlawful practice of physical therapy.

(l) The commission of any fraudulent, dishonest, or corrupt act which is substantially related to the qualifications, functions, or duties of a physical therapist.

(m) Except for good cause, the knowing failure to protect patients by failing to follow infection control guidelines of the board, thereby risking transmission of blood-borne infectious diseases from licensee to patient, from patient to patient, and from patient to licensee. In administering this subdivision, the board shall consider referencing the standards, regulations, and guidelines of the State Department of Health Services developed pursuant to Section 1250.11 of the Health and Safety Code and the standards, regulations, and guidelines pursuant to the California Occupational Safety and Health Act of 1973 (Part 1 (commencing with Section 6300) of Division 5 of the Labor Code) for preventing the transmission of HIV, Hepatitis B, and other blood-borne pathogens in health care settings. As necessary, the board shall consult with the Medical Board of California, the California Board of Podiatric Medicine, the Board of Dental Examiners of California, the Board of Registered Nursing, and the Board of Vocational Nursing and Psychiatric Technicians, to encourage appropriate consistency in the implementation of this subdivision.

The board shall seek to ensure that licensees are informed of the responsibility of licensees and others to follow infection control guidelines, and of the most recent scientifically recognized safeguards for minimizing the risk of transmission of blood-borne infectious diseases.

6. Section 2661.5 of the Code states:

(a) In any order issued in resolution of a disciplinary proceeding before the board, the board may request the administrative law judge to direct any licensee found guilty of unprofessional conduct to pay to the board a sum not to exceed the actual and reasonable costs of the investigation and prosecution of the case.

(b) The costs to be assessed shall be fixed by the administrative law judge and shall not in any event be increased by the board. When the board does not adopt a proposed decision and remands the case to an administrative law judge, the administrative law judge shall not increase the amount of the assessed costs specified in the proposed decision.

(c) When the payment directed in an order for payment of costs is not made by the licensee, the board may enforce the order of payment by bringing an action in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee directed to pay costs.

(d) In any judicial action for the recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(e) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license or approval of any person who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license or approval of any person who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one year period for those unpaid costs.

(f) All costs recovered under this section shall be deposited in the

Physical Therapy Fund as a reimbursement in either the fiscal year in which the costs are actually recovered or the previous fiscal year, as the board may direct.

7. Section 2620.7 of the Code states:

A physical therapist shall document his or her evaluation, goals, treatment plan, and summary of treatment in the patient record. Patient records shall be maintained for a period of no less than seven years following the discharge of the patient, except that the records of unemancipated minors shall be maintained at least one year after the minor has reached the age of 18 years, and not in any case less than seven years.

8. Section 2630 of the Code states:

It is unlawful for any person or persons to practice, or offer to practice, physical therapy in this state for compensation received or expected, or to hold himself or herself out as a physical therapist, unless at the time of so doing the person holds a valid, unexpired, and unrevoked license issued under this chapter.

Nothing in this section shall restrict the activities authorized by their licenses on the part of any persons licensed under this code or any initiative act, or the activities authorized to be performed pursuant to Article 4.5 (commencing with Section 2655) or Chapter 7.7 (commencing with Section 3500).

A physical therapist licensed pursuant to this chapter may utilized the services of one aide engaged in patient-related tasks to assist the physical therapist in his or her practice of physical therapy. "Patient-related task" means a physical therapy service rendered directly to the patient by an aide, excluding non-patient-related tasks. "Non-patient-related task" means a task related to observation of the patient, transport of the patient, physical support only during gait or transfer training, housekeeping duties, clerical duties, and similar functions. The aide shall at all times be under the orders, direction, and immediate supervision of the physical therapist. Nothing in this section shall authorize an aide to independently perform physical therapy or any physical therapy

procedure. The board shall adopt regulations that set forth the standards and requirements for the orders, direction, and immediate supervision of an aide by a physical therapist. The physical therapist shall provide continuous and immediate supervision of the aide. The physical therapist shall be in the same facility as, and in proximity to, the location where the aide is performing patient-related tasks, and shall be readily available at all times to provide advice or instruction to the aide. When patient-related tasks are provided to a patient by an aide, the supervising physical therapist shall, at some point during the treatment day, provide direct service to the patient as treatment for the patient's condition, or to further evaluate and monitor the patient's progress, and shall correspondingly document the patient's record.

The administration of massage, external baths, or normal exercise not a part of a physical therapy treatment shall not be prohibited by this section.

9. Section 2655 of the Code states:

As used in this article:

(a) "Physical therapist" means a physical therapist licensed by the board.

(b) "Physical therapist assistant" means a person who meets the qualifications stated in Section 2655.3 and who is approved by the board to assist in the provision of physical therapy under the supervision of a physical therapist who shall be responsible for the extent, kind, and quality of the services provided by the physical therapist assistant.

(c) "Physical therapist assistant" and "physical therapy assistant" shall be deemed identical and interchangeable.

10. California Code of Regulations, title 16, section 1399, states:

AA physical therapy aide is an unlicensed person who assists a physical therapist and may be utilized by a physical therapist in his or her practice by performing nonpatient related tasks, or by performing patient related tasks.

A(a) As used in these regulations:

A(1) A 'patient related task' means a physical therapy service rendered directly to the patient by an aide, excluding nonpatient related tasks as defined below.

A(2) A 'nonpatient related task' means a task related to observation of the patient, transport of patients, physical support only during gait or transfer training, housekeeping duties, clerical duties and similar functions.

A(b) 'Under the orders, direction and immediate supervision' means:

A(1) Prior to the initiation of care, the physical therapist shall evaluate every patient prior to the performance of any patient related tasks by the aide. The evaluation shall be documented in the patient's record.

A(2) The physical therapist shall formulate and record in the patient's record a treatment program based upon the evaluation and any other information available to the physical therapist, and shall determine those patient related tasks which may be assigned to an aide. The patient's record shall reflect those patient related tasks that were rendered by the aide, including the signature of the aide who performed those tasks.

A(3) The physical therapist shall assign only those patient related tasks that can be safely and effectively performed by the aide. The supervising physical therapist shall be responsible at all times for the conduct of the aide while he or she is on duty.

A(4) The physical therapist shall provide continuous and immediate supervision of the aide. The physical therapist shall be in the same facility as and in immediate proximity to the location where the aide is performing patient related tasks, and shall be readily available at all times to provide advice or instruction to the aide. When patient related tasks are provided a patient by an aide the supervising physical therapist shall at some point during the treatment day provide direct service to the patient as treatment for the patient's condition or to further evaluate and monitor the patient's progress, and so document in the patient's record.

A(5) The physical therapist shall perform periodic re-evaluation of the patient as necessary and make adjustments in the patient's treatment program. The re-evaluation shall be documented in the patient's record.

A(6) The supervising physical therapist shall countersign with their first initial and last name, and date all entries in the patient's record, on the same day as patient related tasks were provided by the aide.@

11. Section 725 of the Code provides in pertinent part as follows:

ARepeated acts of clearly excessive prescribing or administering of drugs or treatment, repeated acts of clearly excessive use of diagnostic procedures, or repeated acts of clearly excessive use of diagnostic or treatment facilities as determined by the standard of the community of licensees is unprofessional conduct for a physician and surgeon, dentist, podiatrist, psychologist, physical therapist, chiropractor, or optometrist.@

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FIRST CAUSE FOR DISCIPLINE

(Aiding and Abetting the Unlicensed Practice of Physical Therapy)

12. Respondent is subject to disciplinary action under section 2660, subsections (j) and (k), of the Code in that respondent aided and abetted the unlicensed practice of physical therapy. The circumstances are as follows:

A. Respondent owns and operates Academy Rehabilitation at 900 Wilshire Blvd., Suite 450, Santa Monica, California where respondent provides physical therapy services directly to patients.

Patient L.T.

B. On or about March 5, 1999, respondent first saw and evaluated patient L.T. at her office. Subsequently, physical therapy services were provided to patient L.T. on various dates, including March 10, 12, 19, 24, 29, 31 and April 2, 1999. On those

dates the physical therapy services included soft tissue mobilization, joint mobilization and neuromuscular reeducation, which services may only be provided by a licensed physical therapist, but which were provided by a physical therapy aide. On the above dates, the physical therapy services also included hot pack and phonophoresis. The record does not reflect any documentation of delegation of these duties to an aide nor of any supervision provided to the aide. Neither the aide nor respondent signed the patient record for the above-noted dates.

C. On or about March 10, 12, 19, 24, 29, 31 and April 2, 1999, respondent aided and abetted the unlawful practice of physical therapy by permitting an physical therapy aide to provide physical therapy services that only a licensed physical therapist may provide, as more specifically set forth in subparagraph 12.B. above.

D. On or about March 10, 12, 19, 24, 29, 31 and April 2, 1999, respondent aided and abetted the unlawful practice of physical therapy by permitting a physical therapy aide to provide physical therapy services without proper supervision, as more specifically set forth in subparagraph 12.B. above, as required by section 2630 of the Code and California Code of Regulations, title 16, section 1398.44.

Patient W.B.

E. On or about April 26, 1999, respondent first saw and evaluated patient W.B. at her office. Subsequently, physical therapy services were provided to patient W.B. on April 26, 1999, through May 7, 1999, by Amy Burns, an unlicensed individual.

F. On or about April 26, 1999, through May 7, 1999, respondent aided and abetted the unlawful practice of physical therapy by permitting an unlicensed individual to provide physical therapy services that only a licensed physical therapist may provide.

SECOND CAUSE FOR DISCIPLINE

(Lack of Proper Record Documentation)

13. Respondent is subject to disciplinary action under section 2620.7 of the

Code in that respondent failed to properly document patient files. The circumstances are as follows:

A. The facts and circumstances alleged in paragraph 12.A. are incorporated here as if fully set forth.

Patient A.C.

B. On or about February 14, 2000, respondent first saw and evaluated patient A.C. at her office. In the evaluation of the patient, respondent set goals to decrease patient A.C.=s pain and inflammation but never gave any indication of the existing level of pain and inflammation. Since the evaluation was incomplete, respondent failed to properly document the patient file.

C. Respondent=s treatment plan for patient A.C. included hot/ice, phonophoresis, soft tissue massage, joint mobilization, medical exercise therapy and shoulder rehab. The patient was seen eight times through March 15, 2000. Respondent wrote and signed all of patient A.C.=s progress notes. The progress notes never describe how the treatments were provided, its frequency, the duration of the treatments or the patient=s response to the treatments. Since the progress notes were incomplete, respondent failed to properly document the patient file.

D. Respondent=s records for patient A.C. include a progress update dated March 15, 2000, but does not otherwise contain a discharge summary that reflects whether the initial goals set were met. Since the patient chart did not contain a complete discharge summary, respondent failed to properly document the patient file.

Patient J.H.

E. On or about April 30, 1999, respondent first saw and evaluated patient J.H. at her office. In the evaluation of the patient, respondent set goals to decrease patient J.H.=s pain and inflammation but never gave any indication of the existing objective level of pain and inflammation and did not sign the evaluation. Since the

evaluation was incomplete, respondent failed to properly document the patient file.

F. Respondent=s treatment plan for patient J.H. included hot pack, phonophoresis, soft tissue massage, joint mobilization, and medical exercise therapy. The patient was seen five times through May 14, 1999. Respondent wrote and signed all of patient J.H.=s progress notes. The progress notes never describe how the treatments were provided, its frequency, the duration of the treatments or the patient=s response to the treatments. Since the progress notes were incomplete, respondent failed to properly document the patient file.

Patient D.G.

G. On or about May 29, 1998, respondent first saw and evaluated patient D.G. at her office. In the evaluation of the patient, respondent set goals to decrease patient D.G.=s thigh pain and spasm, increase knee movement, increase hip strength and increase balance and function. The patient was seen on May 29 and June 5, 1999. Respondent wrote and signed the progress notes. The progress notes never describe how the treatments were provided, its frequency, the duration of the treatments or the patient=s response to the treatments. Since the progress notes were incomplete, respondent failed to properly document the patient file.

H. Respondent=s records for patient D.G. do not include a discharge summary that reflects whether the initial goals set were met. Since the patient chart did not contain a complete discharge summary, respondent failed to properly document the patient file.

Patient E.N.

I. On or about November 29, 1999, respondent first saw and evaluated patient E.N. at her office. In the evaluation of the patient, respondent set goals to decrease patient E.N.=s pain and inflammation but never gave any indication of the objective existing level of pain and inflammation. Since the evaluation was incomplete,

respondent failed to properly document the patient file.

J. Respondent=s treatment plan for patient E.N. included hot pack, ultrasound, soft tissue mobilization left knee, medical exercise therapy, gait training, balance training and proprioception training. The patient was seen six times through December 13, 1999. Respondent wrote and signed all but one of patient E.N.=s progress notes. The progress notes never describe how the treatments were provided, its frequency, the duration of the treatments or the patient=s response to the treatments. Since the progress notes were incomplete, respondent failed to properly document the patient file.

K. Respondent=s records for patient E.N. do not include a discharge summary that reflects whether the initial goals set were met. Since the patient chart did not contain a complete discharge summary, respondent failed to properly document the patient file.

Patient C.G.

L. On or about March 30, 1998, respondent first saw and evaluated patient C.G. at her office. In the evaluation of the patient, respondent set goals to decrease patient C.G.=s pain but never gave any indication of the existing level of pain. The evaluation was not signed. Since the evaluation was incomplete, respondent failed to properly document the patient file.

M. Respondent=s treatment plan for patient C.G. included hot packs, ice packs, ultrasound, joint mobilization, soft tissue mobilization and medical exercise therapy. The patient was seen ten times through April 26, 1998. Respondent wrote and signed all of patient C.G.=s progress notes. One progress note, for April 26, 1998, was not signed. The progress notes never describe how the treatments were provided, its frequency, the duration of the treatments or the patient=s response to the treatments. Since the progress notes were incomplete, respondent failed to properly document the

patient file.

N. Respondent=s records for patient C.G. include a discharge summary dated April 24, 1998, which was not clearly written making it difficult to determine if the initial goals set were met. The discharge summary was not signed by respondent. Since the discharge summary was illegible and unsigned, respondent failed to properly document the patient file.

Patient B.W.

O. On or about February 16, 1998, respondent first saw and evaluated patient B.W. at her office. In the evaluation of the patient, respondent set goals to decrease patient B.W.=s pain but never gave any indication of the existing level of pain and did not sign the evaluation. Since the evaluation was incomplete, respondent failed to properly document the patient file.

P. Respondent=s treatment plan for patient B.W. included hot pack, soft tissue mobilization, range of motion, flexibility exercises, back rehab program and activities of daily living for return to work. The patient was seen fifteen times through March 19, 1998. Respondent wrote and signed all of patient B.W.=s progress notes. The progress notes never described how the treatments were provided, their frequency, the duration of the treatments or the patient=s response to the treatments. Since the progress notes were incomplete, respondent failed to properly document the patient file.

Q. Respondent=s records for patient B.W. does not include a discharge summary that reflects whether the initial goals set were met. Since the patient chart did not contain a complete discharge summary, respondent failed to properly document the patient file.

Patient L.T.

R. On or about March 5, 1999, respondent first saw and evaluated patient L.T. at her office. In the evaluation of the patient, respondent set goals to decrease patient

L.T.=s pain and inflammation but never gave any indication of the existing level of pain and did not sign the evaluation. Since the evaluation was incomplete, respondent failed to properly document the patient file.

S. On or about January 10, 2000, respondent again saw and evaluated patient L.T. at her office. In the evaluation of the patient, respondent did not set any goals and did not sign the evaluation. Since the evaluation was incomplete, respondent failed to properly document the patient file.

T. Respondent=s treatment plan for patient L.T. included hot pack, ice pack, phonophoresis, medical exercise therapy, soft tissue mobilization and joint mobilization. Respondent wrote and signed some of patient L.T.=s progress notes. The patient was seen seven times through April 2, 1999. The progress notes never described how the treatments were provided, their frequency, the duration of the treatments or the patient=s response to the treatments. Since the progress notes were incomplete, respondent failed to properly document the patient file.

Patient H.C.

U. On or about January 10, 2000, respondent first saw and evaluated patient H.C. at her office. In the evaluation of the patient, respondent set goals to decrease patient H.C.=s pain and inflammation but never gave any indication of the existing level of pain and inflammation. Since the evaluation was incomplete, respondent failed to properly document the patient file.

V. Respondent=s treatment plan for patient H.C. included hot pack, ultrasound, manual therapy, soft tissue, gentle joint mobilization, and medical exercise therapy. Respondent wrote and signed all of patient H.C.=s progress notes. The patient was seen thirteen times through March 17, 2000. The progress notes never described how the treatments were provided, their frequency, the duration of the treatments or the patient=s response to the treatments. Since the progress notes were incomplete,

respondent failed to properly document the patient file.

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Patient H.Z.

W. On or about July 17, 2000, respondent first saw and evaluated patient H.Z. at her office pursuant to a referral from Joey Liu, M.D., who was treating her due to a motor vehicle accident. Dr. Liu=s referral cited cervical strain, and requested evaluation and treatment twice a week for three weeks. Based on respondent=s initial evaluation, treatment for patient H.Z. was to include hot pack, ultrasound, soft tissue and joint mobilization, medical exercise, kinetic activities and ADL (activities of daily living). A specific treatment plan was not set forth.

X. Respondent saw patient H.Z. approximately 28 times on the following dates, providing essentially the same treatments on each occasion: July 17, 19, 21, 24, 26, 28, 31, 2000; August 2, 4, 7, 9, 21, 23, 30, 2000; September 1, 6, 9, 11, 13, 18, 20, 27, 29, 2000; and October 4, 6, 11, 13, 16, 2000. The treatments provided were hot pack, ultrasound, soft tissue and joint mobilization, medical exercise, kinetic activities and ADL (activities of daily living). The progress notes did not describe how the treatments were provided, the frequency, the duration of the treatments or the patient=s response to the treatments.

Y. On or about August 1, 2000, patient H.Z.=s attorney, who was representing her in connection with a motor vehicle accident, requested copies of the patient=s chart and billings. Thereafter, respondent provided some medical records but no billing records. On or about October 19, 2000, a second request was sent to respondent for copies of the patient=s chart and billings. On or about November 8, 2000, respondent advised H.Z.=s attorney that billing records would not be provided until patient H.Z. paid for the treatment or a lien was signed. On or about November 8, 2000, patient H.Z. wrote to respondent advising her that Health and Safety Code section

123110(g) provided that health care providers could not withhold patient records because of an unpaid bill for health care services. On or about November 14, 2000, a representative of respondent indicated to patient H.Z.=s attorney that respondent had no obligation to further respond since patient H.Z. had not signed a lien or otherwise paid her balance due.

Z. Since the progress notes for the physical therapy services provided by respondent to patient H.Z., as more fully set forth in subparagraph 12.X. above, did not describe how the treatments were provided, the frequency, the duration of the treatments or the patient=s response to the treatments, respondent failed to properly document the patient file.

THIRD CAUSE FOR DISCIPLINE

(Dishonesty)

14. Respondent is subject to disciplinary action under section 2660, subdivision (l) of the Code in that respondent committed fraudulent, dishonest, or corrupt acts which were substantially related to the qualifications, functions, or duties of a physical therapist. The circumstances are as follows:

A. The facts and circumstances alleged in subparagraphs 13.L., 13.M. and 13.N. are incorporated here as if fully set forth.

B. On or about April 17, 1998, respondent billed Medicare for physical therapy services for patient C.G. on that date. Respondent did not provide physical therapy services to patient C.G. on or about April 17, 1998. On or about March 15, 1998, respondent was reimbursed for the physical therapy services billed for April 17, 1998.

C. On or about April 17, 1998, respondent committed a fraudulent, dishonest, or corrupt act which was substantially related to the qualifications, functions, or duties of a physical therapist when she billed Medicare for a service that had not been performed.

Patient L.T.

D. The facts and circumstances alleged in subparagraphs 12.B., 12.C., 12.D., 13.R., 13.S. and 13.T. are incorporated here as if fully set forth.

E. On or about July 3, 2001, when an office audit of respondent=s practice was conducted, respondent=s progress notes in the records for patient L.T. were unsigned. On or about November 1, 2001, respondent provided records under subpoena which had been altered by adding respondent=s signature to the progress notes.

F. On or about November 1, 2001, respondent committed a fraudulent, dishonest, or corrupt act which was substantially related to the qualifications, functions, or duties of a physical therapist when she altered the patient records of patient L.T. as more fully described above in subparagraph 13.E. above.

G. On or about March 10, 12, 19, 24, 29, 31 and April 2, 1999, respondent billed United Health Care for physical therapy services, that required performance by a licensed physical therapist, as if they had been performed by respondent when in fact they had been performed by a physical therapy aide, inasmuch as contrary to California Code of Regulations, title 16, section 1399, respondent did not ensure that the aide documented the patient chart for respondent to countersign, with her first initial and last name, and date on the same day as patient related tasks were provided by the aide.

H. On or about March 10, 12, 19, 24, 29, 31 and April 2, 1999, respondent committed fraudulent, dishonest, or corrupt acts which were substantially related to the qualifications, functions, or duties of a physical therapist when she billed for physical therapy services that required the performance of a licensed physical therapist when the services had been performed by a physical therapy aide, as more fully described above in subparagraph 14.G. above.

FOURTH CAUSE FOR DISCIPLINE

(Gross Negligence)

15 Respondent is subject to disciplinary action under section 2660,

subsection (h), of the Code in that she was grossly negligent in her practice as a physical therapist. The circumstances are as follows:

A. The facts and allegations in paragraphs 12.W. through 12.Y. above are incorporated here as if fully set forth.

B. Between July 17 and October 16, 2000, respondent was grossly negligent in her practice as a physical therapist based on (1) providing excessive physical therapy treatments to patient H.Z. for an extended period of time without a treatment plan; (2) failing to document patient H.Z.=s patient file as to how the treatments were provided, the frequency, the duration of the treatments or the patient=s response to the treatments; and (3) failing to timely provide patient H.Z.=s chart and billing information to her attorney.

FIFTH CAUSE FOR DISCIPLINE

(Excessive Treatment)

16 Respondent is subject to disciplinary action under section 725 of the Code in that respondent provided excessive physical therapy treatments to a patient. The circumstances are as follows:

A. The facts and allegations in paragraphs 12.W. through 12.Y. above are incorporated here as if fully set forth.

SIXTH CAUSE FOR DISCIPLINE

(Unprofessional Conduct)

17 Respondent is subject to disciplinary action under section 2660 of the Code in that respondent engaged in unprofessional conduct. The circumstances are as follows:

A. The facts and allegations in paragraphs 12 through 16 above are incorporated here as if fully set forth.

PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein

alleged, and that following the hearing, the Physical Therapy Board of California issue a decision:

1 Revoking or suspending Physical Therapist Number PT 9186, issued to Jane E. Savaheli;

2 Ordering Jane E. Savaheli to pay the Physical Therapy Board of California the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 2661.5;

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3 Taking such other and further action as deemed necessary and proper.

DATED: __June 17, 2003_____

_Original Signed By
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STEVEN K. HARTZELL
Executive Officer
Physical Therapy Board of California
Department of Consumer Affairs
State of California
Complainant